

**LAC+USC MEDICAL CENTER & HEALTHCARE NETWORK ATTENDING STAFF ASSOCIATION  
DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF ANESTHESIOLOGY**

NAME OF APPLICANT \_\_\_\_\_ DATE \_\_\_\_\_

Initial Appointment and/or Additional Privileges       Reappointment

**Applicant:** Check off only those privileges expected to be performed at the site where you will be working. Note that privileges granted may only be exercised at the site(s) and setting(s) recommended by the Department Chair/Chief/Designee. Shaded areas indicate that the privilege is not applicable for that particular entity.

**Department Chair/Chief/Designee:** Initial the Recommended column for approved privileges. If applicable, check off the "Not Recommended" boxes. Documentation of all privileges must be provided for all privileges on the last page of this form.

DESCRIPTION OF PRIVILEGE		RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Ctr.			Competency	Other
	<b>Core Privileges in Anesthesiology:</b> includes performing a history and physical, interpreting laboratory studies, interpreting and performing diagnostic studies and treatment plans for the following ages:			
	Neonates and Infants from 0 to 2 years of age			
	Children from 3 to 13 years of age			
	Adolescents and Young Adults 14 years of age and older			
	<b>General Anesthesia</b>			
	1. Techniques of rendering a patient insensible to pain during surgery, obstetrics and certain medical or radiologic diagnostic interventions.			
	2. Support of life functions during the stress of anesthesia and surgery.			
	3. Management of patients unconscious from whatever cause.			
	4. Treatment of fluid electrolyte and metabolic disturbances.			
	5. Supervision of certified or qualified nurse anesthetists.			

REQUESTED LAC+USC Medical Center	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			Competency	Other
	6. Perform History and Physical Examinations, provide consultation, including pre-op assessment for the following ages:			
	7. Neonates and Infants from 0 to 2 years of age			
	8. Children from 3 to 13 years of age			
	9. Adolescents and Adults from 14 years of age and older			
	<b>Local and Conductive Anesthesia</b>			
	1. Peripheral Nerve Block			
	2. Subarachnoid Block			
	3. Epidural Block			
	4. Caudal Block			
	5. Intravenous Regional (Bier) Block			
	6. Stellate Ganglion Block			
	<b>Special Procedures</b>			
	1. Direct Arterial Line			
	2. Central Venous pressure line			
	3. Swan-Ganz Catheters			
	4. Hypotensive technique			
	5. Respiratory care, nebulizer therapy, etc.			

Name: \_\_\_\_\_

REQUESTED LAC+USC Medical Center	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			Competency	Other
	6. Temporary Transvenous Pacing*			
	7. Transesophageal Echocardiography*			
	8. CPR including the direction of such efforts			
	9. Intrapleural Catheters			
	10. Fiberoptic bronchoscopy			
	11. Ventilator control			
	12. Management of patient controlled analgesia devices			
	<b>Pain Management Privileges*</b>			
	1. Neurolytic nerve blocks			
	2. Neurolytic spinal, epidural or caudal blocks			
	3. Insertion of implantable epidural or subarachnoid catheters to be attached to infusaport or infusion pump (to be done with surgical consultant)			
	4. Utilization of cryoprobe for freezing peripheral nerves			
	5. Celiac plexus block			
	6. Insertion of epidural dorsal column stimulator			
	7. Insertion of peripheral nerve stimulator			
	8. Use of fluoroscopy **			

Name: \_\_\_\_\_

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other

**PRIVILEGES NOT INCLUDED ON THIS FORM:** A request to perform any procedure or treatment not included on this form must be submitted to the Attending Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.

**TEMPORARY CLINICAL PRIVILEGES:** In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted as per the LAC+USC Attending Staff Association Bylaws.

**ACKNOWLEDGMENT OF PRACTITIONER:**

I hereby certify that I have no physical or mental impairment which would interfere with my practice, and I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise in each group of procedures requested. I understand that in making this request I am bound by the LAC+USC Bylaws and/or policies of the hospital and medical staff.

\_\_\_\_\_  
 APPLICANT'S SIGNATURE

\_\_\_\_\_  
 DATE

Name: \_\_\_\_\_

REQUESTED LAC+USC Medical Center	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			Competency	Other

Department Chair/Chief/Designee:

**If there are any recommendations of privileges that need to be modified or have conditions added, indicate here:**

Privilege#: \_\_\_\_\_  
 Condition/Modification/Explanation: \_\_\_\_\_  
 \_\_\_\_\_

**If privileges are NOT recommended based on COMPETENCY, provide explanation:**

Privilege#: \_\_\_\_\_  
 Explanation for NOT recommending based on  
 COMPETENCY: \_\_\_\_\_  
 \_\_\_\_\_

If supplemental documentation provided, check here:

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

\_\_\_\_\_  
 SIGNATURE OF THE DEPARTMENT CHAIR/CHIEF/DESIGNEE

\_\_\_\_\_  
 DATE

APPROVED BY CREDENTIALS & PRIVILEGES COMMITTEE ON:	APPROVED BY EXECUTIVE COMMITTEE ON:
APPROVED BY GOVERNING BODY ON:	PERIOD ENDING:

Name: \_\_\_\_\_